Date: [Insert Date]

Patient Name: [Insert Name]
Date of Birth: [Insert DOB]
Patient ID: [Insert ID]

Subject: Discharge Summary - Weight Management Program

Dear [Patient Name / Primary Care Physician],

This letter confirms that [Patient Name] has completed the Obesity and Weight Management Program at [Facility Name] and is being discharged from our active care effective [Discharge Date].

Clinical Summary:

- **Initial Weight/BMI:** [Insert Data]
- **Discharge Weight/BMI:** [Insert Data]
- **Total Weight Change:** [Insert Data]
- **Co-morbidities Monitored:** [e.g., Hypertension, Type 2 Diabetes]

Treatment Provided:

[Insert brief summary of interventions: e.g., Nutritional counseling, physical activity plans, pharmacotherapy, or behavioral therapy].

Ongoing Management Plan:

- **Dietary Recommendations:** [Insert instructions]
- **Physical Activity:** [Insert frequency and type]
- **Medications:** [Insert current weight management medications or changes]
- **Follow-up:** [Insert instructions for primary care follow-up]

Discharge Status:

[Insert status: e.g., Goal weight achieved / Transitioning to community-based support / Patient request].

If there are any concerns regarding weight regain or related metabolic complications, please contact [Contact Information] for a re-referral.

Sincerely,

[Provider Name]
[Title/Department]
[Facility Name]